QUESTION PRESENTED

Whether ERISA preemption exempts self-funded or self-insured employee benefit plans from state insurance statutes enforceable against insured employee benefit plans and licensed insurance companies, where such statutes are neither directed specifically to employee benefit plans nor core ERISA provisions.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

No. 89-1048

FMC CORPORATION,

Petitioner,

v.

CYNTHIA ANN HOLLIDAY,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Third Circuit

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BRIEF *AMICUS CURIAE* OF AMERICAN PODIATRIC MEDICAL ASSOCIATION IN SUPPORT OF RESPONDENT

The American Podiatric Medical Association submits this brief *amicus curiae* in support of respondent. Letters granting consent, received from counsel for each of the parties, are being filed together with this brief.

STATEMENT OF INTEREST OF *AMICUS CURIAE* AMERICAN PODIATRIC MEDICAL ASSOCIATION

The American Podiatric Medical Association (APMA) is a voluntary membership association rep-

resenting over 9,000 licensed doctors of podiatric medicine practicing in each of the 50 states, Puerto Rico and the District of Columbia. Podiatry, or podiatric medicine, is regulated in each of the fifty states as a recognized healing art, along with medicine, osteopathy, dentistry, optometry, and other licensed providers of heatlh care. In some jurisdictions, podiatric medicine is regulated by independent statute; in others, licenses are granted pursuant to the medical practice act which likewise regulates the practice of medicine.[1] APMA is a District of Columbia non-profit corporation with its principal office in Bethesda, Maryland. APMA exists as a confederation of state podiatric medical associations.

An estimated nine and one half million Americans receive their health care benefits from self-funded welfare benefit plans.[2] Many such plans provide benefits for foot care. However, some of these plans, together with traditional insurance contracts contain benefit provisions excluding or restricting the coverage of podiatry; i.e., distinguishing between podiatric physicians and other licensees authorized to care for the human foot. This discrimination against podiatrists led to the enactment of state "freedom of choice" or "non-discrimination laws" requiring that third party payment of health care costs be determined without regard to the degree or license held, provided that the service rendered was within the scope of such practitioner's license. It is the position of APMA that this Court's opinion in the instant case

[1] See for example, Code of Virginia, Section 54.1 - 2929, et. seq.

[2] See Petitioner's brief, p.4 n.2 citing U.S. Dept. of Labor, Bureau of Labor Statistics, Bulletin 2336 (August 1988).

will likely decide questions which will have a significant effect on the applicability of "freedom of choice" and "non-discrimination laws" to employee welfare plans. Thus, as the national organization representing the interest of doctors of podiatric medicine, APMA hereby respectfully submits this brief *amicus curiae* in support of the brief of respondent, Cynthia Ann Holliday and the Third Circuit's holding in this case. APMA further submits that this Court's disposition of the instant case should not adversely affect, and should in fact reaffirm, the efficacy of "freedom of choice" laws as unimpaired by the preemption provision of ERISA.

SUMMARY OF ARGUMENT

This case deals with the applicability of state insurance laws to self-funded employee benefit plans. Specifically, the Court is being asked to consider whether the Pennsylvania Motor Vehicle Financial Responsibility Law is enforceable against such plans. The answer lies in the meaning of Section 514 of ERISA, 29 U.S.C. Sec. 1144: 1) is the state law preempted by ERISA? 2) is the state law "saved" from preemption? and 3) does the "deemer" clause excuse self-funded plans from compliance with the state law?

The initial focus in ERISA preemption cases has been whether the state law "relates" to employee benefit plans. A law may have so indirect an effect on such plans as to fall outside the scope of the "relates to" test. The Pennsylvania anti-subrogation and "freedom of choice" statutes are laws directed to all applicable third party payers and not specifically di-

rected to employee benefit plans. The anti-subrogation law poses no true burdens on the administration of employee benefit plans and conflicts with no ERISA provisions. Nevertheless, the Court of Appeals has noted that the anti-subrogation law is a law relating to the plan and is a law regulating insurance. The outcome of this case rests on the scope of the "deemer" clause. The Third Circuit has, after consideration of precedent, legislative history and common sense, concluded that the deemer clause provides a narrow exception to the application of insurance laws to self-funded employee benefit plans. The savings clause permits the states to enforce the insurance laws notwithstanding general ERISA preemption. That a self-funded plan should not be "deemed" an insurance company for purposes of any insurance law regulating insurance companies or insurance contracts should, in no way, interfere with a state's right to enforce its insurance laws. The deemer clause refers to a narrower set of laws than *all* insurance laws saved from preemption and applies only to such state statutes which directly or deliberately conflict with central provisions of ERISA. Anti-subrogation laws as well as "freedom of choice" laws are saved from preemption and do not relate to core ERISA provisions so as to be inapplicable to self-funded plans.

ARGUMENT

State insurance laws must bear a relation to employee benefit plans so as to be preempted by ERISA.

I. State "freedom of choice" laws do not "relate" to employee benefit plans and thus, are not preempted by ERISA.

This case deals primarily with the scope of insurance laws saved from federal preemption pursuant to

ERISA section 514 (b)(2)(A) and the limitations on enforcement of such insurance laws by the "deemer" clause of ERISA section 514 (b)(2)(B). Earlier cases have dealt with the three-pronged ERISA preemption concept; namely, whether a state law sufficiently "relates" to benefit plans as to be superseded by ERISA (29 U.S.C. section 1144 (a)), whether the state law is a law which "regulates insurance" and is thereby saved from preemption (29 U.S.C. Section 1144 (b)(2)(A)), and whether the plan to which the state law is being applied is being "deemed" to be an insurance company or other insurer or to be engaged in the business of insurance for purposes of any law purporting to regulate insurance companies or insurance contracts, (29 U.S.C. Section 1144 (b)(2)(B)).

Typically, ERISA preemption analysis commences with a determination of the state law's relationship to employee benefit plans. The Third Circuit in the instant case, citing this Court, determined that a "law relates to an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such plan." *FMC Corporation v. Holiday*, 885 F.2d 79, 84, (3rd Cir. 1989), citing *Shaw v. Delta Airlines*, 463 U.S. 85, at 96, 97, 103 S.Ct. 2890 at 2900, 77 L.Ed. 2d 490, (1983). In *Shaw*, this Court ruled that New York's Disability Benefit and Human Rights laws "related" to employee benefit plans. Nevertheless, this Court observed that certain "state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." *Shaw*, 463 U.S. at 100 n.21, 103 S.Ct. at 2901 n.21.

In *Holliday*, the Third Circuit held that the Pennsylvania anti-subrogation law "related" to employee

benefit plans and would have been preempted, absent the applicable "savings clause" concerning state insurance laws. Petitioner's broad interpretation results in a lack of uniform application of state laws providing the public with equal access to and reimbursement for health care services rendered by any licensed practitioner.[3] APMA believes, these "freedom of choice" laws relate to employee benefits, but not to employee benefit plans. This distinction was recently discussed and set forth by this Court in *Fort Halifax Packing v. Coyne*, 482 U.S. 1, 107 S.Ct. 221, 96 L.Ed. 2d 1, (1987), wherein it was held that a Maine law prescribing severance payments in the event of plant closings was not a law relating to employee benefit plans, but a law relating only to employee benefits. Similarly, "freedom of choice" laws do not relate to employee benefit plans; rather they merely provide that, if a particular health condition is subject to reimbursement by whatever agreement the individual has established, any licensed provider shall be entitled to reimbursement for any service performed within the scope of the provider's license. APMA agrees with *amicus* American Optometric Association (AOA) that

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[3] Numerous states have enacted laws to protect the right of equal reimbursement for medical services rendered by a podiatrist or medical doctor; for example, in Pennsylvania, "[n]otwithstanding any provision or any policy of insurance, self-insured sickness health and/or welfare plan providing benefits issued or renewed after the effective date of this act, whenever such policy or plan provides for reimbursement for any service which may be legally performed by a person licensed under the laws of the Commonwealth for the practice of medicine, osteopathy . . . [or] podiatry . . . reimbursement under such policy or plan shall not be denied when such service is rendered by a person so licensed." 40 Pa. Stats. at 1511.

such laws "are outside the scope of ERISA's preemption clause." AOA brief, p. 9. These laws, contrary to the Massachusetts law considered in *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985) do not mandate that a particular service be covered, do not force the employer to haphazardly provide for a particular service and do not require any modification to the administrative procedures of any employee benefit plan. "Freedom of choice" laws do not "establish a plan. . . .generate. . . .no program activity that normally would be subject to ERISA regulation. . . .[pose] no risk either that an employee will evade or that a state will dislodge otherwise applicable federal regulatory requirements. Nor is there any prospect that an employer will face difficulty in operating a unified administrative scheme for paying benefits." *Fort Halifax Packing Company v. Coyne*, 482 U.S. at 15.

APMA firmly believes that, like "freedom of choice" laws, the Pennsylvania anti-subrogation law is too "tenuous, remote or peripheral" [*Shaw* 463, U.S. at 100 n.21] to fall within ERISA's scope of preemption, meant to minimize interference with the administration of employee benefit plans.

Nevertheless, assuming the Supreme Court determines now, or at some future time that "freedom of choice" laws "relate to" ERISA plans, APMA agrees with respondent and the Third and Sixth Circuits that, notwithstanding the "deemer" clause, certain insurance laws "saved" from preemption apply to self-insured employee benefit plans.

II. The "deemer" clause does not preclude state regulation of self-insured employee benefit plans as to all state insurance laws otherwise saved from preemption.

Assuming, the Third Circuit was correct in holding the preemption provisions of ERISA applicable to state subrogation laws, there remains the analysis of the "savings" and "deemer" clauses (29 U.S.C. Section 1144 (b)(2)(A) and 29 U.S.C. Section 1144 (b)(2)(B)). This case essentially arises from conflicting interpretations of these ERISA provisions. The petitioner asserts that ERISA preempts self-funded benefit plans, such as that operated by FMC, from state insurance laws because the ERISA "savings" clause does not apply to self-insured plans pursuant to the "deemer" clause.

In support of this broad interpretation of the "deemer" clause, petitioner relies on *Metropolitan Life Insurance Co. v. Massachusetts*, as the basis for the distinction between self-insured plans and insured plans. Specifically, the petitioner cites this Court's observation that its decision in *Metropolitan Life* results in a distinction between insured and uninsured plans leaving the former open to indirect regulation while the latter are not. *Metropolitan Life*, 471 U.S. at 747. The Third Circuit, on the other hand, determined that this inconsistent treatment of insured and self-insured employee benefit plans merely meant that while

> under *Metropolitan Life* [,] insured plans would *per se* survive the deemer clause. . .self-insured plans would merely be considered on a case by case basis as to whether the state regulation involves a central concern of ERISA.

FMC Corp. v. Holliday, 885 F.2d 79, 89 citing *Northern Group Services Inc. v. Auto Owners Insurance Co.*, 833 F.2d 85 (6th Cir. 1987), cert. denied, 108 S.Ct. 1754 (1988).

In essence, petitioner argues that, as a consequence of the deemer clause, a state "may not directly or indirectly regulate a self-funded employee benefit plan that does not purchase any insurance products." (Petitioner's brief, p. 16). Petitioner has misinterpreted the deemer clause and, consequently, the true intent of this Court's observation in *Metropolitan Life*. Rather than exclude self-insured plans from all insurance laws, "[t]he deemer clause protects ERISA plans from being deemed insurers, or otherwise in the business of insurance by any state law 'purporting' to regulate insurance companies or insurance contracts." *FMC v. Holliday*, 855 F.2d 86, 87. Summarizing the three-pronged ERISA preemption test, the Third Circuit concluded that

> the preemption clause preempts nearly any state law relating to employee benefit plans, second, the savings clause carries out the narrow but sizable exception of state laws regulating insurance; and finally, the deemer clause guards against any insurance regulation that infringes on such ERISA areas as reporting, disclosure, and nonforfeitability.

FMC v. Holliday, 885 F.2d 88. The appellate court properly distinguishes between what is "saved" by 29 U.S.C. Section 1144 (b)(2)(A) and what is to be protected by the "deemer" clause (29 U.S.C. Section

1144 (b)(2)(B)). A close look at the two provisions reveals that the savings clause protects from preemption *"any law* of any state *which regulates insurance"* (emphasis added)." The deemer clause, on the other hand, narrowly protects self-insured plans from those laws purporting to regulate insurance companies or insurance contracts. Health insurance has been defined as

> A contract or agreement whereby an insurer is obligated to pay or allow a benefit of pecuniary value with respect to the bodily injury, disablement, sickness, death by accident or accidental means of a human being, or because of any expense relating thereto, or because of any expense incurred in prevention of sickness, and includes every risk pertaining to any of the enumerated risks.

Blacks Law Dictionary, 5th Ed (1979), pp. 722-723. This is precisely what the FMC plan provides (see petitioner's brief, p.4 n.1). An insurance contract is the policy of insurance entered into between two parties. "A policy of insurance is the written instrument in which a contract of insurance is set forth." *Id*, p. 1042. Thus, the "savings" clause saves from preemption state laws regulating the insurance concept while the "deemer" clause protects self-insured plans from state laws regulating the policy itself. This distinction was recognized by the Sixth Circuit's holding in *Northern Group Services*, that a state no-fault coordination of benefits law, requiring insurers to offer certain benefit provisions, was saved from preemption and not subject to the deemer clause as applied to self-funded plans. (*Id.*, 833 F.2d 85). The plans contained coordination of benefit provisions seeking to

make the liability of the employee benefit plans secondary to state mandated no-fault automobile insurance. The plan provisions were in conflict with the state law which "mandates that no-fault carriers offer coordination of benefits at reduced premiums when the insured has other health and accident coverage." Mich Comp. Laws Section 500.3109a.

Petitioner does not contest the district and appellate court determinations that the Pennsylvania Statute "regulates insurance within the meaning of the insurance savings clause" (Petitioner's brief, p. 13, citing *FMC*, 885 F.2d 86). The scope of what is encompassed by the "savings clause" is illustrated by this Court's statement that a court "must presume that Congress did not intend to preempt areas of traditional state regulation." *Metropolitan Life*; 471 U.S. at 740, 105 S.Ct. at 2389. It has been well-established that state regulation of insurance goes beyond the so-called "business of insurance" governed by the McCarran-Ferguson Act, 15, U.S.C. Section 1011 et. seq. (1976). This Court has held that

> many aspects of insurance companies are regulated by state law, but are not the "business of insurance" . . . state regulation of a practice of an insurance company does not mean that the practice is the "business of insurance" within the meaning of the McCarran-Ferguson Act.

Group Life and Health Insurance v. Royal Drug Co., 440 U.S. 205 (1979).

As noted by the Sixth Circuit, this Court "construed the sweep of the savings clause as a whole and in light of the object and policy underlying

ERISA, thus going beyond the meaning imposed merely by application of the McCarran-Ferguson Act factors." *Northern Group Services*, 833 F.2d 94, n.6 citing *Pilot Life Insurance Co. v. Dedaux*, 481 U.S. 41 (1987).

Thus, "begin[ning] with the language employed by Congress and the assumption that the ordinary meaning of that language accurately expresses legislative purpose" *Metropolitan Life*, 471 U.S. 740, (citation omitted), ERISA "saves" more for state regulation than it takes back with the "deemer" clause.

The Sixth Circuit in *Northern Group Services*, recognizing that the "legislative history behind the deemer clause is ambiguous," concluded that "for the deemer clause to override the savings clause in a given case, there must be some ERISA interest in uniformity to outweigh the McCarran-Ferguson interest in state regulation of insurance." Clearly, ERISA is devoid of any language identifying an interest in no-fault insurance, subrogation, or "freedom of choice" laws. Petitioner's contention that Congress intended to save insured plans from preemption while excluding self-insured plans from non-ERISA related state insurance laws suggests that Congress envisioned the "patchwork scheme of regulation" feared by this Court in *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, where the Court stated that

> Congress intended preemption to afford employers the advantages of a uniform set of administrative proceedings governed by a single set of regulations. This concern only arises, however, with respect to benefits whose provisions by nature require an on-

> going administrative program to meet the employer's obligation.

Fort Halifax Packing Co. v. Coyne, 482 U.S. 11.

Petitioner's argument further suggests that employee benefit plans may be treated differently with respect to state insurance laws solely on the basis of whether such a plan is self-insured or commercially insured. APMA agrees with the Third Circuit that

> the proper inquiry under the deemer clause is whether the state insurance regulation intentionally or unintentionally addresses a core type of ERISA matter which Congress sought to protect. . . . The Court reviewing a state insurance law, should inquire whether that law conflicts with any substantive mandate in ERISA.

FMC v. Holliday, 885 F.2d 89, 90.

Said another way, the deemer clause does no more than prevent the states from applying certain insurance laws, i.e., those pertaining to the "business of insurance" and "insurance contracts" to self-funded employee benefit plans. Nevertheless, other forms of insurance regulation remain "saved" from the preemption provisions of ERISA.

CONCLUSION

APMA submits that certain state insurance laws remain "saved" from ERISA preemption, either because such laws do not "relate" to ERISA so as to be preempted, or, alternatively, such laws are insurance laws, applicable to all employee benefit plans. The deemer clause applies only in such cases where

the state seeks to override a true ERISA interest. State statutes which have declared a broad public policy of prohibiting reimbursement discrimination against particular classes of health care practitioners persuasively illustrate the importance of preserving this distinction.

Respectfully submitted,

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